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Vol. XXI. HALIFAX, NOVA SCOTIA. SEPTEMBER, 1909. No. 9

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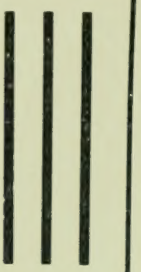

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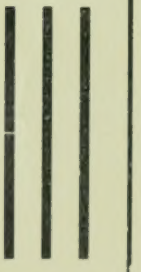

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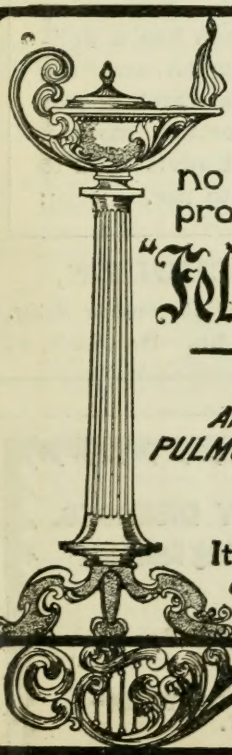

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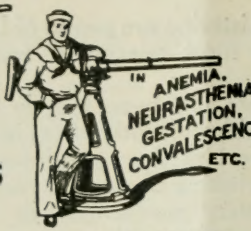

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The Maritime Medical News

Vol. xxi., *SEPTEMBER, 1909*, No. 7.

WORLD OF MEDICINE.

Circumcision and its Abuses.

It is not sufficiently realised that, however advisable circumcision is on hygienic grounds, the anatomical state of the foreskin is by no means frequently sufficient justification for operating. There is much too great a tendency to regard a long and narrow foreskin as in itself a proof that circumcision is needed. Such a foreskin is the characteristic of male babies at birth; while, on the other hand, the penis of the new-born infant is small in size, and frequently very small.

In the new-born babe the glans and prepuce are adherent by reason of the persistence of the epithelial agglutination of the surfaces. Few babies are born with the adhesions fully separated, but separation takes place in the course of some months, and the perfect adult condition is attained about the eighth year.

True congenital phimosis is a rare condition. Sometimes the orifice is constricted, and occasionally it is absent. Constriction of the the orifice may lead to ballooning of the foreskin on micturition, a very evident sign, which quickly attracts the attention of the nurse, for the state of the foreskin in babies seems to be peculiarly interesting to nurses, and the question of circumcision generally arises through their initiative. It is stated that a constricted orifice may lead to dilatation of the urethra, bladder, ureters, and kidneys, giving rise to hydronephrosis and atrophy of the renal tissue. Certainly such results are extremely rare from this cause, but excite undue apprehension in the mind of the family doctor. It is also said to cause the retention, accumulation and decomposition of smegma, eczema and balanitis, preputial calculi, adhesion of the prepuce, narowing of the meatus, urethritis, cystitis, pyelitis, retention, incontinence, and enuresis.

To the local irritation which accompanies some of these affections are ascribed restlessness, insomnia, irritability, paroxysmal screaming attacks, dysuria, frequent micturition, severe colic, and even pain in the hip. Painful micturition is much more probably due to highly acid urine. Masturbation has followed on local irritation, but, on the other hand, the habit is by no means rare in the circumcised, and has has often been ascribed to the effect of circumcision and the friction of clothes on the sensitive glans. Continued mild inflammatory mischief leads to adhesions and the development of a thickened non-retractile foreskin, which subsequent difficulties in coitus and liability to attacks of balanitis. Straining to pass water is supposed to develop or maintain hernia, prolapsus recti, and even hydrocele.

In the course of a very extensive experience of the ailments of infancy the writer has found remarkably lit-

tle confirmatory evidence of the occurrence of these conditions. Many of them are almost unknown.

Let it be clearly understood that mere redundancy of foreskin is no indication for circumcision. The penis develops later, and subsequently the supposed long foreskin may be insufficient to cover the glans completely. If the prepuce can be retracted with moderate ease, it should certainly be left. It is a very valuable protection for the glans. The fact that among the children of the careless and unwashed smegma may accumulate under the prepuce and become offensive is not an argument in favour of operation, but a slur on the person responsible for the welfare of the child.

Circumcision must not be regarded as a trivial and harmless operation, for many evil and fatal results have ensued. Sepsis, sloughing of the skin and ultimately extensive scarring, sloughing and gangrene of the penis, fatal hæmorrhage, erysipelas, and pyæmia have all occurred. Syphilis and tuberculosis have been transmitted when the operation has been done as a religious rite, and not by a trained surgeon. Hæmorrhage is rare, for the Jews remove the skin only, do not cut the mucous membrane, and carefully avoid the frænum, though neither sutures nor ligatures are used. Hæmorrhage is commonly due to neglect to tie the vessels of the frænum.

Apart, however, from serious and fatal sequels, the operation of circumcision may be a source of discredit to the operator and of subsequent trouble to the child. It is by no means rare to find an excessive amount of skin removed. A chronically thickened preputial stump or a mass of redundant skin may give the organ an unkempt and ragged appearance, which spoils the reputation of the surgeon for years and is a constant source of gossip among the female branches of the family, although the inartistic appearance is lost or forgotten.

In many babies it is quite sufficient to separate the adhesions with a probe, without causing bleeding. Others can be treated by dilatation with dressing or artery forceps, until the foreskin can be easily retracted. It is then cleaned, oiled, and replaced. Retraction and oiling should be done daily for a time. This may be left to the mother or nurse if the foreskin can be replaced easily. Otherwise there is the prospect of being hastily summoned to deal with a paraphimosis. If the surfaces bleed on separation, adhesion is almost certain to recur, for the retraction cannot be carried out daily without pain and will be neglected. Failing cure by these simple measures, recourse must be had to complete circumcision; to incision of the mucous membrane only on each side; to longitudinal dorsal incision of the foreskin; or to other modification of the complete operation, depending on the length of the foreskin, the degree of adhesion and stenosis, and the ideas of the parents and operator in reference to the desirability of this operation. Care should be taken not to remove too much skin, leaving enough to cover the corona, and to enlarge a narrow meatus, if present; for this may quite well be the cause of screaming and straining on micturition.—*Hospital.*

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The Colon Tube and the High Enema. The question of how far soft rubber colon tube can be inserted into the bowel to administer an effective high injection, is taken up by H. W. Soper, St. Louis (*Journal A. M. A.*,

August 7th), who describes experiments performed by him in which the position of the tube was verified by the X-ray. Sixty cases were examined where it was attempted to pass long blunt end soft rubber tubes with side openings, into the rectum, the patient being in the knee, chest and side positions. The only case in which he succeeded in passing the tube above the dome of the rectum was one of Hirschsprung's disease or congenital idiopathic dilatation and hypertrophy of the colon, and even here it was necessary to use the sigmoidoscope to introduce the tube. He thinks it is only in cases of abnormal development of the sigmoid that it is possible to introduce a soft rubber tube six inches in length is therefore best for all sorts of enemata when using water for fecal evacuation, and it is possible, as he has frequently demonstrated, to thoroughly cleanse the entire colon by using a large caliber (one-half inch) short tube. It is also best when retention of liquid is desired.

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Physicans and the Materia Medica. Reid Hunt, Washington, D. C. (*Journal A. M. A.*, August 14th), says that while at present, other forms of treatment are coming to public notice than that by means of drugs, that is no valid reason or argument for neglecting drugs. It may be well to recall sometimes Naunyn's remark that were it not for five or six drugs he would not care to be a physician at all. Surgeons especially are prone to forget the influence drugs have had on their art. Many years ago an eminent surgeon expressed the opinion that his specialty had reached the highest conceivable degree of perfection. This might have been true, Hunt says, if it had not been for antiseptic drugs and the discovery and use of general and local anesthetics. The fact that other forms of treatment need as careful study and teaching as that of drugs and that the field of the physician in the prevention of disease is ever widening, is a potent argument for systematizing the study and use of drugs and drug treatment. He shows by illustrative facts that physicians are handicapped by misrepresentation and ignorance in their treatment with drugs. The use of many names for the same article, the direct introduction of powerful drugs to the laity by the use of catchy, self-suggestive names, the sending out of half truths in their recommendations by proprietary drug manufacturers, are noticed as but the logical outcome of the failure of the medical school to support adequate departments of pharmacology and evidence of the necessity of physicians informing themselves on the subject. He points out what has been done and is being done to remedy this state of affairs by the American Medical Association and its *Journal* and by the Council on Pharmacy and Chemistry, and the injustice of the attacks which have been made by interested parties against individual workers for reform. The practicing physician can help in the movement by informing himself and using only the approved remedies of the Council and the Pharmacopeia, and he pleads for the support by the physician of research work in pharmacology.

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Incontinence of Urine. Perrin (*Prov. Med.*, March 6th, 1909), describes the different varieties of urinary incontinence, which, he points out, ought to be distinguished from one another, incontinence being only a symptom and not

a pathological entity. The most frequent form is enuresis, generally occurring in infants and young children. In this form the incontinence is confined to night and the period of sleep, no inconvenience being experienced during waking hours. The only exciting cause which is present at night and absent during the day is the condition of profound sleep in which the subjects of this symptom as usually found. This sleep is of the nature of stupor, and it may be explained by the fact that it generally coexists with adenoids, nasal polypi, goitre, etc., and is cured when when these are removed. Insufficient aëration of the blood produces a state of lethargy in the patient, the cerebral centre being rendered less sensitive. In that condition the call to empty the bladder gets no farther than the medulla, where it is translated into action without the restraining influence of the brain. If the removal of the obstructing cause is not sufficient, the faradic current will succeed in re-establishing the forgotten connexion between the brain and the bladder. Incontinence occurring during the day as well as at night is generally found to depend on some amount of cystitis, caused either by microbes or by a mechanical cause, such as phimosis. In the adult the symptom may arise from an enlarged prostate, locomotor ataxy or general paralysis, intraurethral tumour, hyperdilatation of the urethra, displacement of the bladder, or injury to the vesical sphincter.

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Salt and Smoke.

For some time past the public taste has been gradually growing in favour of the mild-cured article, with the result that at the present moment strong salted or smoked foods are not in evidence as they used to be and are rarely called for. The ham and the bacon must be mild cured, and even butter must be fresh and absolutely without a salt flavour. This preference for the so-called mild-cured article has undoubtedly furnished an excuse on the part of caterers for the use of stronger antiseptics than salt or smoke, and antiseptics which are, comparatively speaking, tasteless, or at any rate which add no special flavour to the food. The old-fashioned antiseptics, salt and smoke, are thus sharply distinguished from modern antiseptics, inasmuch as the former not only preserved food but served also as condiments. In the case, however, of certain preserved foods, although the salt may be left out, the smoke must be retained, as otherwise the food loses its individuality. The kipper, for example, is inseparable from a smoky flavour, as is also dried haddock or dried salmon. We have heard that a "smoke essence" is employed to impart the kind of palatability associated with properly smoked food, but such practices, coupled with the use of antiseptics, would readily account for the regrettable fact that cured articles of diet are not now up to their former standard. Assuming that the mild-cured article, and as a particular example we may choose butter because it is an indispensable article of the dietary, is free from objectionable antiseptics, it is still left more helpless against the attacks of micro-organisms than were the old-fashioned cured foodstuffs. Experiments have, in fact, shown that the addition of salt to butter is a factor of great importance from the point of view of germs. In unsalted butter the growth of micro-organisms is more vigorous and continues for a longer time than is the case with salted butter. Mycelial fungi if pres-

ent disappear entirely after a while in salted butter, while in fresh or unsalted butter they multiply rapidly. The quality of butter appears to be improved by a small percentage of salt (say 2.5); it encourages the development of a flavour which makes butter an attractive article of food and it acts as a safeguard. Altogether there would appear to be certain valid reasons for thinking that the public preference for the mild-cured article may be an error of judgment, and there certainly is much to be said in favour of the old policy of preserving foods by salt and by smoke. —*Lancet.*

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Colchicum in Gout. The use of colchicum in the treatment of gout still continues to be a subject concerning which diverse opinions are held. In the judgment of some physicians, the deleterious effects sometimes produced by colchicum render its administration a risky proceeding, whilst other leading teachers of medicine believe in its exhibition in suitable cases. Some prescribe the drug in large doses; others again declare that it should be given only in small amounts; some aver that colchicum, if it is to be of service, must purge the patient; whilst there are a large section of medical men, gradually increasing in number, who do not regard purgation as necessary. The fact is undoubted that colchicum can alleviate pain in the gouty and produce a speedy amelioration of the distressing symptoms, but the objection is still sometimes urged, that though it relieves the pain, it may produce a return of the affection. On this point competent observers have failed to note any tendency to relapse after efficient treatment with colchicum, and modern investigations show that colchicine has has an important action on the leucocytes, which at first are diminished in number in the circulation, and then reurn in increased numbers. As pointed out in Dr. Sikes' communication in this issue, perhaps the leucocytes are stimulated in some way to act on the gouty poison in the system. —*Practitioner.*

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Functions of Omentum. An interesting paper on the Functions of the Omentum was recently read before the Académie Royale de Médecine de Belgique by Heger and Heger-Gilbert. In a first series of experiments, a few c.c. of physiological salt solution, in which animal charcoal had been suspended, were injected into peritoneal cavity of various animals. Care was taken to spread the solution over the whole of the peritoneum. The particles were subsequently found to have collected in the omentum, which had become thicker than normal. Microscopical examination showed the leucocytes, which were extremely abundant, to be engaged in an active phagacytosis of the charcoal particles. This action took place in both the lesser and greater omentum. In a second series of experiments metallic particles were used instead of charcoal, and a series of radiographic pictures taken. The photographs showed the gradual accumulation of the metal in the omentum, a fact which was subsequently verified in post-mortem. On the other hand, in animals such as young rabbits, in which the omentum is ill-developed, the metallic particles remain scattered throughout the abdominal cavity. The same is true of animals—e. g., the frog and fish, in which the diaphragm is absent. In a third series of experiments larger foreign bodies, such as glass beads,

particles of lead and cork were introduced. As a rule these were rapidly encysted by the omentum, which hypertrophied in their neighbourhood. The glass beads were in some cases seen to travel along the lymphatic channels and to accumulate near the great curvature of the stomach. Some even collected near the origin of the thoracic duct. Heavier foreign bodies, such as lead particles, do not migrate in this manner, but become encysted *in situ* by the omentum. These encysted bodies eventually leave the omentum, and may be found almost anywhere in the abdominal cavity, a fact which may explain the presence of "foreign bodies" sometimes found in the abdomen at autopsies. Occasionally the encysted bodies ulcerate through an adjoining coil of intestine and are passed per rectum, a general infection being prevented by omental adhesions. The authors were also able to show by experiments that a similar protective function to that of the omentum is possessed by the large ligaments of the female pelvis.—*Hospital.*

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Ochsner's Treatment of Appendicitis. In an interesting contribution to the *American Journal of Surgery*, Dr. J. M. Barnhill, of Ohio, discusses Ochsner's Treatment of Appendicitis. He appears to be justified in his supposition that Ochsner's methods of treatment are not properly understood by a certain proportion of the profession, and his authority and records have been referred to in support of non-operative treatment of appendicitis. One of the essential principles of Ochsner's teaching is to operate early; in fact, he adopts the extreme surgical standpoint, that operation should be performed as soon as a diagnosis of acute appendicitis has been made. But he differs from the current text-book teaching in regard to cases which come under treatment after the infection has extended beyond the tissues of the appendix, and especially in the presence of beginning diffuse peritonitis. In such cases he advocates delay in surgical intervention until the patient's condition has been sufficiently improved to render operation safe. He does this because he claims to have medical measures at his command which are able to effect such an improvement and justify delay—namely absolute fasting by the mouth, and rectal feeding and rectal saline injections. In cases of severe vomiting he resorts also to gastric lavage. In all cases of appendicitis he deprecates the administration of food or cathartics by the mouth as long as there is any pain or other evidence of inflammation. Rest being one of the first essentials of treatment for any form of inflammation, everything should be done to ensure absolute rest of the bowel, and so prevent spread of infection. Briefly, therefore, the chief features of Ochsner's treatment are to withhold everything by the mouth and administer food and saline by the rectum, operate in all ordinary acute cases; but when there is evidence of spread of infection to the general peritoneum wait for a subsidence of severe symptoms by the measures above mentioned.

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The Enzyme Treatment for Cancer Final Report. William Seaman Bainbridge of New York (*Medical Record*, July 17, 1909), gives a final report on the results of treatment of cases of inoperable cancer, or cancer in which operation has been refused, after two years of experience. He considers it definitely proven that the enzyme treat-

ment does not cure cancer, does not prevent metastasis, and does not check the cancerous process. Internal medication with holadin and oxgall aids digestion and increases elimination; lotio pancreatis applied locally clears the ulcerating surface by removing organisms, thus diminishing absorption of their products; and resistance is increased by this regime. Control cases injected with glycerine and water do as well as those treated with enzymes. Injection of trypsin in some cases causes more rapid disintegration of cancerous tissues, and may accelerate the breaking down of cancer tissue in the center of the mass, the edge going on growing actively. It may be a menace to life by eroding large blood vessels and by overwhelming the system with toxic products. The injections are painful and objected to by the patients. Trypsin abscesses may be produced due to broken-down tissues and unabsorbed trypsin. Injections of amylopsin may cause lessened cachexia. Hemogoblin, polymorphonuclear neutropile cells, and eosinophile cells are increased.

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A Contribution to the Study of Tremors. M. Neustaedter of New York (*Medical Record*, July 17, 1909), has made a study of the different kinds of tremor, and has devised an instrument for recording the sort of movements in each tremor, so that they may be differentiated. The pathology of tremors is very obscure. Various lesions in different portions of the nervous system have been found to account for the movements of flexion and extension causing the tremor. His apparatus consists of a kymograph, a tambour of the Marcy type, with a string attached to the lever and fastened by a hook to a piece of rubber adhesive plaster, and a recording tambour with a paper writing point. The two tambours are connected by a rubber tube. The affected part is placed in a comfortable position and the adhesive strap attached to it. The author has made 328 tremograms of all the diseases in which tremor exists, and finds that the different types of tremor may be distinguished by the records they make. He gives the typical curves of each kind of tremor. The difference between tremors is of kind, not of degree, and every form of tremor is distinctive of a group of diseases. No definite relation exists between one form of tremor and another. The frequency of movements has no bearing upon the character of the tracing. There is no material difference between the movements of the two sides of the body.

EDITORIAL.

GRADUATED WORK FOR CONSUMPTIVES.

EXERCISE or a moderate amount of work has been more or less resorted to in the treatment of consumptives at sanatoria for various reasons needless to detail. The value of graduated work has been overshadowed by the importance attached to rest. The methods first introduced and extensively tried by Dr. Paterson at the Frimley Sanatorium with such excellent results will, no doubt, sooner or later, have the effect of giving to properly regulated work an importance equal to that of rest. The Frim-

ley Sanatorium is situated near London and is a Branch of the Brompton Hospital for diseases of the chest, an institution which has a world-wide reputation. The sanatorium accommodates 150 patients, who are carefully selected at the Brompton Hospital, and only such cases as are likely to receive some benefit from treatment, are admitted. Advanced cases with favourable symptoms are not excluded. The average stay of a patient in the sanatorium is 160 days. If there is no improvement in six weeks the patient is usually discharged. Very little medicine is used. The treatment at first is fresh air, careful feeding and rest. When the temperature and pulse rate have become normal and good digestion and assimilation have been established, graduated work or exercise is prescribed and the amount carefully increased as improvement progresses. Careful clinical observation and the opsonic index are the main factors in determining the increase of work.

The grades of work and exercise are roughly as follows:—Grade 1: Persons unfit for active exercise make mops, mats, sew, etc. Grade 2: Walking from a half to six miles a day. Grade 3: Picking up wood, carrying baskets filled with different things that have to be moved, watering plants and so forth. Grade 4: Using a small shovel, cutting grass edges, hoeing and so forth. Grade 5: Digging broken ground, mowing grass and such like. Grade 6: Trenching, mixing concrete, felling trees, etc. Sometimes persons who do not improve while doing light work gain markedly on being given harder labour. If unpleasant symptoms should develop, rest is again tried for a time.

Graduated work is thought to be useful by bringing about auto-inoculation with tuberculin, a view which is supported by the studies of Wright, Inman and Rothschild.

Rothschild states that "tuberculin "stored up in the vicinity of the dis-"eased focus may be transferred to "the blood by systematic measured "movement and in this way an artifi-"cial exaltation of the opsonic con-"tent of the blood may be secured. "Thus by intelligent arrangement of "work and rest periods auto-tubercu-"linization may be made therapeu-"tically available." This theory cannot be definitely adopted as yet, The experience of the Frimley Sanatorium establishes beyond doubt the beneficial effect of carefully regulated muscular exertion and that so long as exercise is unattended with any symptom and without fatigue it can be safely increased from day to day until a degree of exertion about equal to an ordinary day's work can be reached. The gain is a great one inasmuch as the discharged patient is fit to resume his employment the moment he returns to his home, thus avoiding the risks of insufficient nutrition due to scarcity of means. Further, the tendency of the rest cure to make patients lazy and indifferent about their future is to a large extent averted. An experiment tried at the Massachusetts State Sanatorium at Rutland may be noted. For some years the more promising patients have been permitted to play baseball, a rather strenuous form of exercise, with on the whole, very beneficial results.

CAESARIAN SECTION.

By MURDOCH CHISHOLM, M. D.,

Halifax, N. S.

(Read before the Meeting of the Maritime Medical Association, Charlottetown, P.E.I., July 14, 1909.)

THE origin of Cæsarian section is veiled in obscurity. The possibility of its successful accomplishment may have dawned upon humanity by accident, and the credit of initiating the operation may not belong to man. Since 1646, writes Harris in the American System of Midwifery nineteen years ago, no less than eleven women far advanced in pregnancy, were made the subjects of gastro-hysterotomic rips by infuriated bulls, with a saving of eight women and five children! This, by the way, is the best proof I have ever yet seen or heard of the Modernists' ancestry. This, too, may explain Shakespeare's account of the famous Macduff, who was an exception to other mortals, by being not born but ripped out. I remember a woman well who was disembowelled by an ox, and was afterwards sewn up by my father with an ordinary needle and thread. Had this woman been pregnant this animal might have won the palm of priority in Cape Breton for the operation of Cæsarian section.

The operation may also have been the child of dire necessity or prolonged agony, which may unhinge the mental soul and leave the body a prey to desperation. An ignorant Jamaica slave is known to have thus sought relief from her sufferings with entire success, and five other women in the last one hundred and forty years have been known to do likewise. (*American Journal Medical Sciences*, Feb, 1888). Scarcely less tolerable than the pain of the sufferer is the anguish of an affectionate relative or an impressionable bystander. This accounts for the first successful case of Cæsarian section recorded in Europe. It happened in Switzerland in the year 1500, and the hero, Jacob Nufer, was the woman's husband—a gelder, a spayer of cattle, and used to the knife. This may also account for the practice of the operation by the uncivilized races of Uganda. Robert S. Felkin, F. R. S. E., of Scotland, in 1879, details the operation as he saw it done by these savages. The peculiar features were that the operator washed his hands and the abdomen with palm wine, thus ante-dating Lister, and the closure of the abdominal wound by long pins and figure of 8 sutures.

Having said so much about the probable origin of Cæsarian section I will go on to consider its indications, prognosis and technique.

Its indications are laid down in the text books as absolute and relative. An absolute indication is impossible delivery, as when the anteroposterior diameter is not more than two inches. A relative indication is possible delivery' either by craniotomy, symphysiotomy or pubiotomy. Between three and three and a half inches it is possible to deliver a child by craniotomy without much danger to the mother. But here the question arises, why should we ever destroy a life when there is any fair chance of saving it? I must say that with our increasing knowledge and facilities we are not justified in resorting to craniotomy. With local hospitals and larger operative experience, the obstetrician should not hesitate to recommend Cæsarian section, where in other days he resorted too lightly, perhaps, to craniotomy, i. e., in cases with a conjugate diameter up to from three to three and

a half inches. I would also lay down as an absolute indication cases like my third one, where previous deliveries have been so hard as to result in the death of the child. Also, cases of transverse presentation, where it is impossible to turn without undue force, which may result in rupture of the uterus.

Lastly, the indication for Cæsarian section is absolute when the mother of a viable child dies suddenly or by accident. Children have been saved in this way when delivered twenty-five minutes after death by accident. In death from convulsions or pre-existing disease, we must be more prompt if we would save the child.

Mortality. This is now quoted at 5%. After its professional inauguration by Trautemann of Wittenburg, in 1610, it ranged as high as 79%. This high mortality resulted in its discontinuance for centuries. Then with the advent of better technique and antisepsis, the mortality fell to its present proportions. In my experience of three cases the mortality has been nil, and the feeling after each operation has become a conviction that it is the most humane and scientific treatment of pronounced dystocia. In one of my cases the operation was done the second time, and this though, at the previous operation, both Falloppian tubes were tightly tied by silk ligatures. I now tie with two ligatures, cut the tubes between them and then overlap the tubes and sew them in this position. The prognosis is largely modified by the state of the patient at the time of operation. If she come in early at the commencement of labour, if she be not exhausted by long hours of ineffectual suffering, if she be not infected by frequent examinations and rupture of the membranes, the prognosis is good in the hands of any careful surgeon.

Case 1. Mrs. Meagher, aged 27. Seen in consultation with Dr. Corston, June 23rd, 1909. Married about five years. Has had two children. First born alive but died some time after. Labour exceedingly hard. Two years afterwards, confined again. Turning. After-coming head extracted with great difficulty. Neck of child broken in delivery.

Patient short, thick and stout. Examination per vaginam very difficult; cervix uteri very high. Unable to touch promontory of sacrum owing to some narrowing of outlet, which is hard to define. In labour a few hours. Patient in much dread, having suffered intensely from previous confinements and convalesence being very tedious. Recommended removal to hospital for Cæsarian section, this being indicated not absolutely, but relatively. A strong desire to have a living child and some manner of escape from the suffering of her previous confinements, were the factors which influenced the patient in choosing Cæsarian section.

Removed to hospital June 23rd, 9 p m., and prepared for operation. Drs. Hogan, Hawkins, McDonald, and Roach assisting. Dr. Hawkins to press with both hands upon the loins in order to raise the uterus and keep it in firm contact with the abdominal walls. Dr. Hogan to control the uterine hæmorrhage by pressure on each side of the incision. Drs. McDonald and Roach to take charge of the baby. Abdominal incision five to six inches long. Umbilicus about midway. Lower end of incision about three inches from pubes. Important to remember that the bladder in pregnancy is carried upwards some distance above the pubes. Uterine incision. First incision short, about two inches. Free bleeding, controlled by pressure. After cutting through uterine wall with the knife came upon the

placenta. Inserted finger and with large straight scissors cut rapidly upwards and downwards till the opening was about five or six inches in length. I then quickly inserted my left hand, separating the placenta, grasped a knee, extracted the child and handed it to Dr. McDonald. Then, extracted placenta and membranes. Now ordered injection of ergot, but uterus remained uncontracted for about five minutes. Inserted eight deep No. 11 silk stitches and as many superficial ones. Uterus being sewn both Falloppian tubes were tied, cut, over-matched and sewn. Removed blood clots, washed with saline solution, and sewed up abdominal wound. Patient left table in good condition.

Patient had considerable pain that night and was given an eighth of a grain of morphia with another hypodermic of ergot.

Next day at 2.30 p. m., T., 99; pulse, 84. Only two occasions after this did the temperature go above 100, recovery being uninterrupted. Baby was put to the breast on the second day. Though the funicular pulse was good when handed to my assistant, Dr. McDonald, it was with some difficulty that respiration was established.

Case 2. Mrs. Malcom, admitted to the hospital July 26th, 1908, for pregnancy with contracted pelvis. She came in a year ago last May in the same condition and was operated on by Dr. Murphy, assisted by Drs. Hogan and Hawkins, herself and child making an uneventful recovery. At that time both tubes were tied tightly with silk ligatures, but not cut. Now, fifteen months afterwards, she is in labour again. Cæsarian section second time. Tubes now tied, cut and overlapped. Recovery uneventful. She is now the happy mother of two healthy children.

Case 3. Mrs. Toomey, aged 23, admitted into Victoria General Hospital, June 23rd, 1907; discharged July 15th, recovered. Diagnosis, labour complicated by contracted pelvis, with a history of being in labour for over twenty-four hours. Forceps had been applied by Drs. Hawkins and Chisholm I may here say that I was called in consultation by Dr. Hawkins, who stated that the case was one of contracted pelvis, requiring operative measures to save the child. On examination I found the anterposterior diameter contracted. We made it out to be less than four inches. It is hard with the finger only to make correct measurements She was a primipara. I suggested to Dr. Hawkins that though the pelvic diameter was small the baby's head might be also small, and that a careful application of the forceps might be tried before subjecting her to operation. The os by this time was fairly well dilated. The membranes were not ruptured. This was done and forceps applied under chloroform, above the brim. Considerable traction first by one and then by the other failed to engage the head. Patient was then sent to the hospital and operated on as soon as she could be got ready. Tubes tied.

In the after treatment she developed considerable temperature with some discharge per vaginam, which I attributed to some infection consequent on our attempt at instrumental delivery. On the fourth day temperature rose to 102° in the evening. Next morning it fell to 99°, and for several days continued to range from 99° to 101°+. On the tenth day it fell to normal, but continued for several days after this to range from 98 to 100. Gradually the patient's conditiion improved and she left the hospital July 15th.

This patient is again pregnant and is looking forward undaunted to another operation in August or September.

THE DIAGNOSIS AND TREATMENT OF ACUTE INTUSSUSCEPTION.

By DR. A. B. ATHERTON, M. D., L. R. C. P. & S. (Edin.)

Fredericton, N. B.

(Read at Annual Meeting Maritime Medical Association, at Charlottetown, July 7th and 8th, 1909.)

ACCORDING to Treves, about fifty per cent. of cases of intussusception occur during the first ten years of life, half of of these being met with in the first year. After the first year the trouble is most common in the third and fourth decades.

There are four varieties of the disease:—(1) enteric, (2) colic, (3) ileo-cæcal, and (4) ileo-colic. The first variety usually involves the jejunum and ileum, and is generally short. The colic is most common in the descending colon and sigmoid flexure. In the ileo-cæcal form the ileum and cæcum pass into the colon, preceded by the ileo-cæcal valve which forms the apex of the intussusception. In the ileo-colic variety the ileum is prolapsed through the ileo-cæcal valve, the ileum forming the apex.

Out of a hundred cases, forty-four are found to be of the ileo-cæcal variety, thirty enteric, eighteen colic, and eight ileo-colic.

In making a diagnosis, the age of the patient of course counts as an important factor, as the affection occurs so much more frequently in young children. The onset of pain in these cases is usually severe and sudden. At first it is distinctly intermittent; later it becomes more continuous, but with exacerbations. Vomiting is not usually so early or pronounced a symptom as in other forms of acute obstruction of the bowels. Constipation is generally absent, and a discharge of bloody fluid mixed with a little mucus is commonly present. With this there is a good deal of tenesmus. The bloody discharges, as far as I have seen, are of a brighter hue than we get in cases of acute dysentery, for which disease it is apt to be mistaken. In dysentery we have a distinct rise of temperature, while in acute intussusception, during the first few hours at least, there is little or no fever, Furthermore, in the latter the pain is much more acute than in dysentery.

When in a case of intussusception we get neither bloody discharges, nor tenesmus, nor the presence of a sausage-shaped tumor, as occurred in case four of the series reported below, it is impossible to differentiate it from an ordinary one of intestinal obstruction. Its treatment, however, by forcible injections would do no harm, and if this failed to afford relief, a laparotomy would be in order in any case.

I once saw a case of thrombus of the inferior mesenteric vessels which considerably resembled acute intussusception. There were severe pain, bloody stools, and more or less tenesmus present. The young woman had had typhoid fever two or three months before, and seemed to have made a fair recovery when she suddenly developed acute illness accompanied by high fever. At the *post mortem* we found the whole large intestine gangrenous and a nearly healed ulcer in the descending colon. The latter was doubtless the starting point of the thrombus.

Meteorism is usually absent during the first hours of intussusception. In about half the cases a sausage-shaped tumour can be felt in the course of

the transverse or descending colon. Sometimes it can be reached by the finger in the rectum. In infants we often have profound symptoms of collapse. A diarrhœa or the griping produced by a cathartic seems sometimes to be the starting point of the trouble, owing doubtless to some irregular contraction of the bowel muscles.

Among the diseases which resemble most closely acute intususseception is Henoch's purpura, in which we may have an effusion of blood into the intestinal wall giving rise to almost the same symptoms as we get in an intussusception. We, however, find no tumour in Henoch's disease, or if so it is of smaller size. The previous history too may show that the patient has had attacks of erythema or urticaria, or accompanying the abdominal symptoms there may be some purpuric spots on the skin, which would serve to differentiate the disease. Again it seems probable from some of the reported cases of this effusion of blood or serum into the intestinal wall that this trouble may itself give rise to a limited intussusception. It may be almost impossible without an inspection of the bowel to fully establish the diagnosis.

As to the treatment of acute intussusception, formerly the chief reliance used to be placed upon injections of air or warm water, an anæsthetic being often administered in the meanwhile in order to render them more effectual. Of late, however, it seems to be the fashion in some quarters to ignore this measure altogether, some of our most noted surgeons advising an immediate resort to abdominal section and manual replacement of the gut. Judging from my own limited experience I cannot agree with this. One is apt to be influenced more by his own immediate observation than by the opinions of others, however eminent they may be in the profession. I cannot help thinking that the consulting surgeon, who generally sees acute cases at a somewhat late stage of the disease, is apt to undervalue methods of treatment other than operative, because of the fact that it is then often too late for the use of these to prove successful, or because they have been called to the case. In employing injections in these cases I have found it necessary to use a good deal of force in order to succeed. Also, it is well to press a napkin firmly for some minutes against the anus after removal of the nozzle of the syringe, so as to keep up a backward pressure on the bowel and make more certain of its going into place and staying there.

After a faithful trial of this method of treatment, if relief is not obtained, the abdomen must be opened and the intussusception manually replaced. One is sometimes aided in this by the further injection of warm water. The replacement is more easily accomplished by squeezing and pushing on its lower end than by pulling on the bowel from above. After returning the gut any distended coils should be punctured in order to let out the septic gases and fluid which they contain, the punctures being afterwards closed by a continuous Lembert suture. The emptying of these distended coils serves the double purpose of getting rid of poisonous matter and reducing the size of the coils so as to facilitate their return to the abdominal cavity. If the intussusception shows an tendency to recur one may insert a few stitches at such points as seems best to prevent this.

Should reduction of the intussusception be found impossible or the

strangulated gut be gangrenous, the case becomes indeed a desperate one. If the patient seems to be in a condition to stand it, one will probably do best to proceed to excise the gangrenous portion through an incision in the intussusception near the line of strangulation, great care being taken to avoid soiling of the peritoneum. After its excision a running suture is passed through the cut borders of bowel and the incision in the intussusception closed in the ordinary way. A few stitches should also be placed at the neck of the intussusception so as to aid in preventing the adhesions which have formed there from giving way.

If the patient seems unable to stand this operation, an opening may be made in the gut above the obstruction and a Paul's tube be inserted to carry off the intestinal contents temporarily, and subsequently, if the patient survives, a radical operation could be done.

Short-circuiting, or uniting a loop of the gut above the obstruction to a loop below, has sometimes been done instead of resection for this condition, but it does not seem to have found much favour.

Permit me now to report a few cases which have been observed by myself:—

Case I.—At 5 a. m., October 19th, 1883, I was called to see a female child eleven months old, who had always been healthy until two weeks before, when it had an attack of measles with a good deal of bronchitis. Two days before my visit the child was seized with diarrhœa and vomiting, but did not seem to require medical attention. She rested fairly well the night before I saw her till between two and three o'clock, when she awoke with severe pain and vomiting. Also there were thin bloody discharges from the anus, with a very little mucus. I gave seven drops of Tinc. Opii in a little water by rectum and ordered two drops of the same to be given by mouth every hour till the pain was relieved. During the next six hours the patient seemed easier and vomited only a few times while there were but two discharges, of the same character as before. She was very pale and appeared somewhat collapsed. Subsequently the vomiting and bloody motions became more frequent and the child looked worse. At 8 p. m. the pulse was 160 and the temperature 100°. On examination I found a tumour 3½ x 1¾ inches occupying the left side of the abdomen, its longest diameter being parallel to the median line and an inch or so from it. It did not appear to be much tender and was fairly resonant, though not so much so as the rest of the abdomen. There was but little general distension. The anus seemed to be somewhat patulous but no tumour could be reached by the finger.

Feeling convinced that I had to deal with a case of intussusception I at once proceeded to inject warm water, no anæsthetic being administered because of the collapsed condition of the patient. The nozzle of an ordinary Davidson's syringe was introduced and a rag wound around it and pressed well up against the anus to prevent the water from returning while it was being thrown in. After a few syringefuls had been injected there seemed to be some considerable resistance to its further entrance, but I continued to force the water in until I introduced about thirty ounces. During this time I manipulated the tumour in the belly and could feel it gradually move to the right until it disappeared. In a few minutes I allowed the water to escape. About half

the quantity injected came away. On examining the parts after this I thought I could feel a slight hardness in the epigastrium and to the right just below the ribs. I therefore again threw in some more water until there was a gush of greenish fluid from the mouth. Two hours afterwards when I saw the child again she was quite comfortable, and had been so ever since the injections. There had been no further vomiting nor discharges from the bowels. No tumour to be felt. Pulse, 145.

During the ensuing day she had two or three loose stools, but there was no sign of blood in them, and she went on satisfactorily to complete recovery.

Case II.—About the same date as that of the case just related I had another in a boy three years old, who had very similar symptoms and was as promptly relieved by the same treatment. As I cannot find any notes of the case I am unable to give a detailed history of it.

Case III.—B. P. Aet., 25 years. Male. Was laid up with "la grippe" two weeks before I saw him, but had got about well again, when two days before, he felt poorly and suffered from headache. Dr. Fisher, of Marysville, was called and gave a dose of calomel, which acted well in a few hours. Soon afterwards he began to have severe paroxysms of pain accompanied with tenesmus and the discharge of small quantities of thin bloody fluid. I saw him about six hours after the acute symptoms had set in, on the evening of the 6th of April, 1908. I found him writhing about the bed at intervals of a few minutes, complaining bitterly and with each paroxysm feeling a desire to go to stool, and in doing so expelling a few drachms of bloody fluid. The pulse and temperature were normal. There was no abdominal distension, and but little or no tenderness anywhere. No tumour could be felt either through the belly wall or by rectum. Thinking we had an acute intussusception on our hands, we at once began to administer an enema of warm water by means of a fountain syringe held six or seven feet above the bed. This seemed to give rise to increased pain, and he struggled so much against it that we had to give him chloroform. Even then he contined to resist and struggle until about three quarts had been thrown in when Dr. Fisher, who was holding the nozzle, felt some gas pass and at the same time several ounces of fluid gushed from his mouth. Immediately he became quiet and apparently easy. The next twenty-four hours he passed a few loose fæcal motions with no sign of blood in them. There had been but little or no pain since the enema, and in a few day he was quite well again.

The two following cases are ones in which an abdominal section was performed.

Case IV.—On November 21st, 1899, I was asked by Dr. Peake, of Oromocto, to see with him a boy four years of age who lived twelve miles out of town, and who on the morning of the 19th had been seized with severe cramps and vomiting. He had been subject to slight attacks of this kind all his life. His parents gave him a dose of senna tea, but with no result. As the pain and vomiting continued they sent for Dr. Peake on the following day. He administered an enema but nothing came away with it. He then gave four grains of calomel. This also had no effect, and the doctor at his next visit on the following day repeated the enema without relief. I saw him about six in the

evening, and found him suffering at short intervals with severe pain in the belly and occasional vomiting. Pulse was 120, and temperature normal. As far as I could learn the constipation had been complete from the very first not even gas passing. The abdomen was considerably distended, and no tumour could be felt either through its wall or by rectum. There was a little tenderness on the right side, where the pain was most complained of. I advised his immediate removal to hospital for operation. An opiate being first given, he was got to town with but little discomfort.

At 10 p. m. I operated. The presenting coils of bowel were much distended and were allowed to escape. The appendix was found fairly adherent to the neck of the intussusception, which proved to be of the ileocæcal variety. This was ligatured and removed. By pressing upon the lower end of the imprisoned portion of the gut and pulling gently on the bowel above I was able to free it. I found the intussusception very much congested, thickened and hard, especially at its lower end. I now punctured the distended coils in two places and let out a considerable amount of thin fæcal matter. After suturing these punctures I returned the intestine and closed the abdominal wound.

The operation was folowed by a good deal of shock, but the use of a saline enema containing a stimulant, and a hypodermic of an eightieth of a grain of strychnine he rallied fairly well. He soon became very restless, however, and died at 2 a. m.

In this case it is probable that his former attacks of cramps and vomiting were due to appendicitis. Also the old firm adhesions around the rest of the intussusception may have had something to do with the complete obstruction that was present.

The last case I shall mention occurred in the practice of one of the most noted surgeons on the continent. I do not know whether the child had been treated by injections, but I think not. She was just a year old, and there was a good deal of abdominal distension. A laparotomy was done and the bowel replaced all right, but the patient died in a few hours.

PRESIDENT'S ADDRESS MARITIME MEDICAL ASSOCIATION.

(Annual meeting held at Charlottetown, P. E. I., July 7th, 1909.)

By P. C. MURPHY, M. D.,
Alberton, P. E. I.

FELLOWS of the Maritime Medical Association,—A time-honoured custom imposes upon me this evening the duty of reading to you a formal address. While I am keenly sensible of, and deeply appreciate, the distinction you bestowed by electing me your president, I cannot but feel that the honour might easily have been given to a member more deserving and efficient,—to some one amongst you whose locks are silvered by a much longer period of earnest devotion and scientific application in our noble profession than it is my privilege to enjoy.

Since our meeting a year ago the Dread Reaper has been busy, and has broken our ranks in many places. In each of the Provinces over which our jurisdiction extends men who adorned the profession have laid aside the burden, and have gone to that place whence no traveller returns. It is fitting, then ,that on the present occasion, in formal meeting assembled, we should pause for moment in silence by their graves, and in some manner accord a tribute of appreciation of their lives and efforts, and thus express our sorrow for the losses we have sustained by their demise.

The subject which shall occupy our time this evening is one that probably comes nearest the heart of the true physician, viz.: "The educative responsibilities to mankind in general of the family doctor." And I wish in particular to consider these responsibilities as a result of the years of accumulated knowledge which has been his for the seeking, and which is the sum total of the selfless endeavors of our predecessors who have been actuated by the highest ideals from the very beginning of the Healing Art.

Since the days of Hippocrates our profession has been one of genuine philanthropy. The oath which bears his name breathes sentiments surpassed only by those of the Sermon on the Mount, and as votaries of an art revered in every age, ours is certainly a position of the most anxious responsibility. In mediæval, as in ancient times, was not the physician assigned a first place in the heart and confidence of the people? Even among the savage tribes, where his practise is but a cult of mysticism and mimicry, the Medicine Man is a law unto himself,—and in this utilitarian century the medical profession has blazed for itself a trail to the farthest outpost of our advanced civilization, and its members occupy a position of trust, accorded them by the common consent of mankind, which is not enjoyed by men in any of the other walks of life.

The sacred privacy of the home is revealed to him in even a greater degree than it is to any member of the household. From the ushering into the world of the new-born babe until he feels the last heart-throb, when all is passing, his intimate relations with the family (and hence with the race), make him the confidant par excellence. —the Guide, Counsellor, and Friend. Does not then this hopeful trust,—this absolute reliance,—which is unstintingly bestowed on us as medical practitioners, carry with it serious duties and grave responsibilities? Are we meeting them, and treating them,

in the same spirit of devotion and self-sacrifice as did our illustrious predecessors, the result of whose labors we cherish as a priceless heritage? If not we are faithless to our God-given opportunities, and shall certainly be called to an accurate accounting.

In these days of universal knowledge responsibilities devolve upon us in the way of education that were undreamt of by our ancestors. The wizards in our laboratories, silent and almost unseen, are working with tireless energy, and with more assiduous attention than ever did the Alchemists when in search of the Philosopher's Stone. They are toiling day and night to ascertain the data and verify the evidences by the application of which we in turn are to instruct mankind how to avoid the pitfalls that beset its path. If we could stop at the Shakespearian Seven Stages in the evolution and devolution of the species our task might be an easier one; but a pre-natal stage, which might be termed the eighth, fills us with anxiety and makes our burden all the heavier. It is our duty to teach the progenitors at the threshold of generation that even this primitive act is encompassed with risks,—that dangers to the young husband, or young wife, undreamt of by either, may lurk—that the very ecstasy of the moment may be invested with perils more terrible than could be imagined by them. The deadly Coccus of Neisser, or the equally pernicious germ of whose identity we have as yet but little accurate information, may be crouched as the panther for his prey.

Modern Microscopy has revealed so many things unthought of a few years ago that, as conscientious physicians, we must always be on the *qui vive* if we are even to come near satisfying our educative responsibilities. The germ theory of disease unknown half a century ago has largely increased our obligations. We must teach the mother through the period of pregnancy such habits of antisepsis and asepsis as shall fortify her against the hazards of accouchment. And that event safely over, we must apprise her of the many dangers to her offspring in the early years of its development. We must educate her in the beneficial effects of fresh air and sunshine on the healthfulness of her living apartments. She should be informed of the many ways that bacterial pests are disseminated—how the ordinary house-fly has menace in his every buzz, that the common mosquito too, of the genus anopheles, may be the conveyor of malarial poison. We must advise regarding the food eaten and the water drunk. And following along the years of infancy it is to us that first evidence of the Biblical Curse, "The sins of the parents visited on the offspring" will be apparent. Through the years of childhood we must instruct the mother, and warn the father on the advent of the first sign, which neglected, would in a few years spell disaster. The hygiene of the nursery, of the bathroom,—even to the cess-pool,—must all be our special care, and a knowledge of the healthful necessities of each inculcated along modern lines. We also shall be the first to notice evidence of morbid sexuality in the adolescent, and shall have the consequent duty of an early warning. It will be at this stage too that we shall be obliged to instruct sons and daughters, through their parents, on matters of a sexual nature, and sedulously strive to have the minds of the former entirely disabused of the popular misconceptions regarding gonorrhœa with its allied conditions; and the prophylaxis of this, as of that other scourge, tuberculosis, is worthy of more than a passing notice.

The latter disease is now receiving such widespread attention from publicists and people that a knowledge of its dangers, and how to avoid them, is being well disseminated; not so with the former. There is no general spreading of knowledge with regard to it; and on this disease and its dangers I wish to lay special emphasis concerning our duties in an educative sense.

I do not purpose to deal in statistics as that is beyond my province on the present occasion. I desire to plead for more careful instruction to the rising generation through the obvious channels so open to the family physician, and to suggest that they be impressed with the truth that gonorrhea, on the authority of some of our greatest genito-urinary specialists, is, in a large percentage of cases, never cured. We should picture to fathers and mothers of families the unsuspected and incalculable misery that may be in store for their young and pure daughters by contamination in matrimony with the so-called smart young men of the world. Let us impress upon the young men of our clientele the terrible risks they are running when they stray from the path of rectitude to consort with the ordinary woman of the pavement; let us paint for him, too, the awful clinical picture of the blasted life of a young and beautiful wife yet perhaps, his in prospectu only, reduced to a miserable wreck as a result of his early misdeeds. The renowned Gaillard Thomas said once in my hearing that fifty per cent. of his major operations for diseases peculiar to the female generative organs were necessitated as a result of gonorrheal infection. This is a truism recognised by every up-to-date physician, yet how little effort are we making to insist upon the spreading of the important knowledge it implies? How prone are we to allow the young patient thus afflicted to go off with the idea that the terrible malady from which he is suffering can be cured as easily as a bad cold! Every modern medical doctor will readily admit this to be a misleading fallacy fraught with the ruinous consequences.

Rather let all the mothers in the land learn of the true condition of affairs. Allow no false modesty to prevent us from opening up this horrible sore, for as true physicians we know this to be the first step in the mitigation of its hidden terrors. Let us, as practising physicians, be equally as solicitous in imparting information on this point as we are in conveying to a fond mother the results of our scientific knowledge of hydrotherapy, for instance, so useful, when properly directed, in the care of a constitutionally delicate child. Moreover, let us take these guardians of the public morals—the clergymen—into our confidence and instruct them in the dangers of which I have just spoken. How potent is their influence in a social as well as in a religious sense; and how much power can we not exert through them in the way of promulgating information so necessary for the well-being of the community! I shall be accused, perhaps, in some quarters, of speaking too strongly; but I am persuaded it is time to speak out, and time does not permit of the half being said. In these days of the medical nihilist we must perfect ourselves, and the species of whose physical well-being we are, in some way, the guardians; and I submit that we should much better earn our honorarium by attention to the correction of a vicious heredity, by properly instructing our clientele, from pre-natal days so to speak, than by the pouring down of bitter potions, or the application of the surgeon's

knife later on, however useful these may be.

It is a scientific and philosophic truth that whatever we are is largely the resultant of two forces,—heredity and environment; and each is capable of acting, or being acted on by, the other. This is true of us mentally as well as physically. What then is the obvious duty on all sides of the modern physician equipped as he should be? Is it not to endeavour to so adjust, or by his precepts have adjusted, these two forces or conditions with a view to minimizing the evil of the one and enhancing the good of the other? We must act according to this principle in fighting disease, tuberculosis for example, in order to insure success. But this is not enough. When we have gotten over the cruder conceptions of the white plague as an entity of potential danger alike to any other infectious or contagious disease, and when we have found means, as I believe we shall, of destroying in the gross its palpable presence, we shall have to go farther and seek the enemy that lies hidden in the region of the impalpable, and make efforts to destroy him. In other words we shall have to teach and apply the homely maxim—"Begin at the beginning," and try to encourage a system of up-breeding, so to speak, whereby the shortcomings of the weak shall be provided for by mating with the strong—where the process of true "Natural Selection" shall be approved and encouraged. I say "natural selection," for after all is it not the experience of ages that there is an element inherent in our nature which attracts the stout to the slight, the tall to the short, the blonde to the brunette, and so on? This is no utopian idea, but a truth which should be advocated as readily as it is recognized by every physician. And I am persuaded that in the application of this principle, with other adjuncts now so well used, we shall find a means for the total eradication of the Great White Plague without any dislocation of our social system.

There are many other things that might be said did time permit, but in this address I merely wished to indicate the lines along which, to my mind, our energies should be bent, in an educative way, by taking advantage of our special opportunities as family physicians. And by following these methods we cannot be taunted by the cynic with the inexactitude of our science, or the bitterness of our potions. While the world lasts there must of necessity be disease, decay, and death, and it is the work of those wizards of whom I have already spoken to furnish us with exact knowledge for the amelioration of the ills of stricken humanity. When Wright enunciated his Opsonic Theory many of us thought that we saw the rift in the clouds,—the sunbeam on the eastern horizon that was to place us in a position of mathematical certitude in our work, when we could call upon at will these adjuvants to individual man which would buttress him until he had time to bring up his own inherent defensive forces in the shape of those phaygocytic cells before they were overwhelmed by a ruthless enemy that shows no quarter.

We are of those who still believe that along the lines proposed by Wright will be found the Philosopher's Stone, and thus will be lifted forever from the members of our profession the insinuation that we practise an inexact science.

In the meantime we will pursue our daily work, and exercise our special opportunities for the betterment of the world, awaiting with patience the further development of an art which has from the beginning such a record of true charity and philanthrophy.

MY EXPERIENCES WITH ANTITOXIE SERUMS.

By R. McNEIL,

Charlottetown:

(Read at annual meeting Maritime Medical Association, July 7th and 8th, 1909)

WITH our present knowledge of diseases we know that a great many of them are produced by specific germs entering into the living body, each infection is produced by a definite germ, then a conflict begins between the germ and its host and we are called in to render aid to the host.

In many cases whether by specific remedies or by symtomatic treatment we can render good assistance to the patient. Unfortunately in too many instances our efforts prove useless. A good deal of our success depends on the condition of our patient when he or she becomes infected, whether one is capable of producing enough productive material so that when carried into the blood stream it can prevent the multiplication of the enemy.

Some have in them a congenital immunity, while in others we assist in producing an acquired immunity. We can produce immunity for a long period of time against smallpox with vaccinia. The mortality in diphtheria is greatly lessened by the use of antidiphtheritic serum and then it also acts as a prophylactic agent. The same is true of Anthrax.

When we come to deal with others they are less certain in their action, yet I believe that in some cases they do good. I will give you a short report of cases treated by use of serum, not alone but with other drugs.

I. An obstetric case, primipara, small, delicate woman and anæmic. On the fifth day after confinement she took a chill; temperature 104; pulse 120. I gave her an intra-uterine douche of Hyd. Bichlor in the morning. On my second visit conditions no better, tenderness over the uterus; temperature 104, pulse 120. I gave her Hypodermically 10 c.c. Streptolytic serum. Next morning temperature 104, pulse 120. Gave her another intra-uterine douche and 10 c.c. Serum. On that evening her temperature was normal.

I do not give any or much credit to serum in this case as I have had similar results, or even better, by the use of one douche of Hyd. Bichlor.

II. A man 50 years of age, family history nil. Came home one evening after a hard week's work, feeling exhausted and tired. He sent for me and I found him with a temperature of 100, pulse 84. Few hours later I was called again and found that he had had a rigor. I enquired more fully into his case and the only thing that I could find present was a slight bruise over the pubic bone. Deep cellulitis began to spread over the abdomen as high up as the umbilicus, extending up the right side and out into the right arm. On the third day of illness I made four long incisions ranging in length from four to seven inches, four on abdomen, three on arm. This reduced the tension greatly but did not help the patient's condition very materially.

On the following day I made two more incisions on the abdomen and two on the arm. Besides other remedies given I gave him 10 c.c. of Streptolytic Serum every twelve hours with seemingly no benefit. Then I gave it every six hours and as the patient's condition was becoming worse I gave

it every four hours with the results you see on the temperature chart — temperature coming down to 99. The pulse did not come down proportionately with the temperature. Pulse continued rapid for weeks.

At one period of his illness, temperature was nearly 106 and the pulse 160. The pulse remained for a long period in the vicinity of 140. One evening while observing a spot on the abdomen that was very tense and swollen, which I thought the following morning I would have to incise I injected 10 c.c. of Serum into it. On my next visit I found the swelling had almost totally disappeared. From this onward the patient began to improve and finally made a complete recovery.

III. An elderly lady of 63 years of age, healthy, received a scalp wound from a blow accidentally by a stick of wood. She developed erysipelas. On the third day of her illness, Dr. Carruthers and myself gave her three Hypodermics 10 c.c. of Serum every four hours. After the third dose, temperature and pulse became normal and she made a complete recovery. We also gave her iron and quinine and used ichthyol ointment locally.

IV. This was a case of difficult instrumental labour. Primipara. Woman 20 years of age. Pelvis somewhat small, child weighed 9½ lbs. Ten hours after delivery nurse took temperature and found it to be 102, pulse 110. After delivery I took her pulse and found it to be 84, did not take temperature. Naturally we were uneasy and could not say what the cause of temperature was as we had been so careful about disinfection of hands and put out as usual and had better opportunities of doing so in this case than we have had in many others.

She complained of pain in right hip, slight chilliness in the afternoon, and I might mention that the day before her confinement she had a similar chilly feeling to that complained of in the afternoon of the day following her confinement. There was no tenderness over the uterus, but we thought it well to giver her an intra uterine douche although the lochia was normal.

Her condition kept us in suspense for some time owing to her temperature ranging from 103 to 104½, pulse about 120. On the fourth day we began giving Serum, at first every six hours. On the eighth day temperature was normal. We then stopped giving the serum.

On the 10th day temperature went up again to 104½. Again we gave Serum every six hours until the 11th day, when the temperature came down to 101 2-5. On this day we found that an abscess had ruptured into the vagina. One opening near the vulva and another an inch and a half above to the right of the cervix, into which opening I could pass a rubber catheter for six inches. The chart will show you how the temperature ran afterwards.

It was difficult to clean the abscess cavity thoroughly as often as it should be done as the patient had to be anæsthized every time it had to be cleaned.

You will notice the curves of the temperature chart while the serum was given.

V. Another case of interest to me is a little girl, family history good, other members healthy, stunted in growth, short, broad hands and feet; age 17.

Eleven months ago she measured 3 feet 1¼ inches, weighed 50¼ lbs. No signs of puberty. After eleven months of treatment with 5 grs. of Thyroid Ext. three times a day, her weight increased to 55 lbs., height 3

feet 3 inches scant. Breasts are well developed and pubic hair began to grow. Whether the latter phenomenon is a co-incident or not I am not prepared to say. Sometimes owing to headaches we were obliged to reduce the dose to 10 grs. a day.

I could cite other cases where benefit seemed to be obtained and others where no benefit seemed to be obtained but as we had no trained nurses to keep accurate record of our cases it would be useless to offer them.

In all these cases mentioned I have to admit that I did not do my work in a scientific manner as I did not make cultures of the bacteria present. One thing certain is that Serum treatemnt is worthy to be given a fair trial in suitable cases. I believe that in diseases such as pernicious anæmia and scarlet fever, at least anti-streptecoccic serum is a valuable aid in our treatment.

The day is near at hand when every small town must have a laboratory with a qualified bacteriologist in it, especially if the treatment of pneumonia is to be carried on by a vaccine of the pneumococcus. I saw no bad effects produced in any of the cases treated. The only thing besides what I mentioned in my report of cases was an increased flow of urine in one with a low specific gravity patient passing on one day 127 ounces with no albumen.

OBITUARY.

DR. THOMAS MILSOM.

THE death of Dr. Thomas Milsom, of Dartmouth, took place at midnight on Saturday, July 24th, after a short illness.

Dr. Milsom was born at Limerick, Ireland, on April 3rd, 1848. He was the son of an army officer, Colonel Milsom. His early education was received at a private school in Dublin. Shortly after reaching the age of twenty, young Milsom came to America. In 1870 he graduated from Harvard, and on his graduation he came to Halifax, where he practised for a short time. After leaving Halifax he was surgeon on steamers of the Inman line for five years. He made many trips between New York and Liverpool in this capacity, once suffering shipwreck on the Nova Scotian coast when the "City of Washington" was stranded. In 1875 he married Miss Emily Dale, of London, Eng. Shortly after his marriage he came to Dartmouth.

Dr. Milsom took a keen interest in civic life and served as councillor for Ward II for the years 1882 and 1883. He has since served on the School Board. For a number of years he has held the position of medical officer to which he had given a great deal of time beyond what the position demanded or his remuneration warranted.

He took a deep interest in music, and was one of the founders of the Orpheus Club, and continued to be not only an active member but one of the chief executive until two or three years ago when he felt compelled to withdraw. Having a fine tenor voice, a splendid physique and much power, he was a welcome addition to the club. He also was a member of Christ Church choir for some time, where his solos were much enjoyed.

He leaves a widow, one daughter and six sons.

The funeral was one of the largest ever seen in Dartmouth. Members of the medical profession walked in a body. The NEWS extends its sympathy to the bereaved family.

PROVINCIAL MEDICAL BOARD OF NOVA SCOTIA

REGISTRAR'S REPORT.

OWING to the assistance afforded by the work of the Education Committee, the Board during the past year has not been required to hold any but the regular quarterly meetings. The attendance recorded at these meetings has been above the average.

The working of the reciprocity agreement between Great Britain and Nova Scotia has proceeded satisfactorily during the year. Considerable correspondence has taken place between the Registrar and persons seeking information as to the conditions of that agreement and the privileges arising therefrom.

The announcement made last year that a similar arrangement had been finally concluded between Quebec and Great Britain was, it appears, somewhat premature, at least as regards the situation of Quebec, as has been brought out in the course of an extended correspondence between your Registrar and the Council of Physicians and Surgeons, Quebec, and the General Medical Council of Great Britain. An application for registration in Quebec made some time ago by a registered Medical Practitioner holding Nova Scotia qualifications registered in Britain, has been declined or at any rate has not yet been granted. The explanation given by the Council of Physicians and Surgeons, Quebec, to the effect that the modification in their regulations made to meet the agreement with Great Britain could not become operative until approved by legislative enactment seemed reasonable enough at first sight. Beyond that, however, it would appear that the Quebec Council has twice departed from the understood intention of the original resolution as accepted by the General Medical Council. An important object, indeed perhaps the most important, of these agreements between the individual provinces (and countries) and Great Britain is that by means of such agreements it is intended to accomplish collateral reciprocity between these provinces themselves, and this is indeed an essential part and necessary sequence of all such agreements. The reading of the terms of the agreement in the Council (G. B.) Minutes relating to Quebec provides that the Quebec Council will accept for registration in Quebec all persons registered in the British Register. An official copy of a regulation adopted later by the Quebec Council and referring to this resolution would practically exclude residents of all the other provinces of the Dominion, and the same regulation as finally endorsed by the Quebec legislature is still further amended to exclude all other colonies, and would limit the reciprocity scheme practically to residents of Quebec and Great Britain alone. This action on the part of Quebec will no doubt be dealt with by the General Medical Council, as the candidate re-referred to has appealed for redress against the decision of the Council of Physicians and Surgeons, Quebec.

The year just terminated has seen the conclusion of the notorious Dyas case. The appeal made by him under the provisions of the special Act (chap. 52, Acts 1908), was dismissed by the judge, who at the same time upheld the decision of the Board in regard to the falsity of Dyas's certifi-

cates and their further action in erasing his name from the Register. It was hoped that as a result of this decision it would be some time at least before any further attempts would be made in contravention of the efforts of the Board to carry out the provisions of the Medical Act. At the recent meeting of the legislature, however, a bill was introduced with the object of securing from the House of Assembly an order in favour of a person who had not a complete curriculum, that notwithstanding the ruling of the Board he should be forthwith registered without being required to complete a satisfactory course or to take the usual professional examinations for license. The influence of the Board and of the profession was, however, again such that this bill was withdrawn, the person concerned having indicated his willingness to comply with the usual reasonable requirements of the Act.

The matter referred to in last year's report with regard to the employment of an unqualified person as assistant or as "locum tenens," etc., was taken up during the year and a Cautionary Circular declaring that this and certain other actions of an objectionable character would be considered as "infamous conduct in a professional respect" by the Board and would render the person practising such liable to have his name erased from the Register, was authorized to be prepared and issued to the profession, a similar procedure having been some time ago adopted by the General Medical Council of Great Britain.

Complaint having been made to the Board with regard to R. J. Gow, an unqualified person practising at Thorburn and vicinity, Pictou County, the matter was placed in the hands of the Board's solicitor to proceed against him in accordance with the evidence under the Medical Act. The report on this case will be separately submitted by Mr. Davidson. Besides these (the Dyas and Gow cases), several other cases chiefly relating to improper advertising, were disposed of by the Board.

The Preliminary Examinations were held during the last year only once, that is in August, 1908. There were no applicants for May, 1909. This is the first time for over thirty years that such a thing has occurred, and is explainable partly by the fact that the total number of persons entering the medical profession has been reduced during recent years and also because increasing numbers of students are exempt from examination by virtue of High School and Collegiate examination certificates. The following, referring to the examination of August, 1908 is taken from the records:

No. of candidates	7
Passed	1
Passed in all but 1 subject	1
Failed	5

This shows a rather high percentages of failures, but four of the five in the latter class subsequently passed at the Dalhousie Matriculation examinations so as to enable them to enter upon or continue their studies. Including those qualified as above and those exempt by other certificates, 24 names in all were added to the Students' Register, being 14 less than during the previous year.

The idea of allowing the remission of the (Students') registration fee to apply only to persons registered in other provinces who are actually engaged as students in Nova Scotia and not to those who for special reasons seek such registration on their own account, seems reasonable and will be recommended by the Education Committee. Also, the proposal to require and to accept 50%

uniformly on all High School and other certificates coming under the provisions of chapter 1, section 13 of the Board's Announcement, excepting only the regular certificates of the colleges and universities in which the individual pass mark of each college will be accepted in each subject, will be recommended.

As regards the Professional Examinations for License, the records indicate:

September, 1908, seven candidates, of whom five passed, two failed.

April, 1909, eleven candidates, of whom eight passed, three failed, making in all 13 candidates who passed in all subjects.

Of these, 12 were granted the Board's Diploma as licentiates. Issue of the Diploma to the remaining candidate was delayed on account of his being under the required age. The above 12 were subsequently duly registered and these, together with one applicant registered on British certifictes, makes a total adition to the Register of 13 names.

During the year there were at the same time erased nine names (being four less than last year), so that the Register has been increased by four names, the total number on the Register June 30th, 1908, being 629. The total number on the Register June 30th, 1909, was 623.

The erasures were all on account of death. The deceased were:

Bell, George Wism, ...	Kingston Station.	July 8, 1908
Bent, Charles, ...	Truro	Aug. 13, 1909
Goodwin, James Clifford,	Meteghan.....	Feb. 14, 1908
Middlemass, Francis.....	Berwick	Nov. 10, 1908
McDonald, John Farquhar,	Shubenacadie	Nov. 4, 1908
McLennan, Angus.....	Margaree.....	Aug. 27, 1908
Primrose, Samuel C., ...	Lawrencetown ...	July 1, 1908
Randall, William Allan,....	Yarmouth	Aug. 13, 1909
Stanfield, Harold Milfred,	Truro	May , 1908

The money receipts for the year have been as follows:

I. Fees.—		
13, $50 Professional Examination Fees ..		$ 650 00
1, 10 " " " ..		10 00
Supplementary Fees.....		95.00
1, 30 Medical Registration Fee		30 00
1, 2 Additional Qualification Fees.....		2 00
2, 2 Special Registration Certificates .		4.00
5, 10 Preliminary Examination Fees...		50.00
2, 2 Supplementary Examination Fees		4.00
1, 5 Special Examination Fees		5 00
3, 2 Local Examination Fees		6 00
17, 10 Students' Registration Fees.....		170.00
Total Fees.....		$1.026 00
II. Additional Receipts.—		
Sales, Registers and Examination Papers.....		7.75
		$1,033.75

All of which, being $507.75, less than the receipts of last year, has been transferred to the Treasurer and will be accounted for in his financial statement.

Respectfully submitted,

A. W. H. LINDSAY,

Registrar.

Annual Meeting, July 21st, 1909.

ABSTRACT FROM THE ARTICLE, "INTESTINAL WORMS AND APPENDICITIS."

By Dr. FRANCIS D. DONOGHUE,

(In the June, 1909, *Annals of Gynecology and Pediatry.*)

THE value of routine pathological examinations is strikingly illustrated by the marked advance in our knowledge of intestinal parasites which come from examination of removed appendices.

"The diseases resulting from wounds made by members of the 'arthropoda' correspond to the diseases originating from wounds of the intestine caused by entozoa, mainly intestinal parasites." That intestinal

worms may not impair the health in any way is true, just as mosquito bites may be harmless.

The round worm and the pin worm, oxyuris vermicularis, being of world-wide distribution, are the ones which most frequently cause trouble.

The fact that the pin or seat worm may be found high up in the intestinal tract is also a point of interest, as the usual methods employed in combating it must be ineffective.

The presence of entozoa in the appendix has been noted from time to time. No especial significance was apparently attached to the occurrence of these cases by observers until comparatively recently. The success which frequently results from vermifugal treatment in persons apparently suffering from appendicitis is a sufficient reason for again calling attention to the conditions.

Dr. Donoghue reports two cases: one, a girl of twelve years, upon whom he operated; the other, a boy of two and a half years, where no operation was performed. He says:

"To protect our foods from infection from human dejections would seem to be easy, and as the ova of entozoa largely enter the system with food it would seem possible to prevent it.

"Those of us who were brought up in the country are familiar with a multitude of ways by which the ova of entozoa may be spread to vegetables and other foods through (a) open water-closet; (b) either by having it connect with the ordinary barn cellar containing manure, which is afterwards used for fertilizer, or by direct use in many cases of human excreta for garden fertilizing.

"The food-products most liable to garden infection are celery, radishes, tomatoes, lettuce, cucumbers, and strawberries; while from defective drainage, or use of contaminated water for irrigation, we could easily get dangerous water-cress."

He reaches the following conclusions:—

First.—The presence of entozoa in the appendix is a not uncommon cause of appendicitis.

Second.—The form of irritation that presents depends upon the exact location of the cause.

Third.—Pin worms do not confine their activity to the rectum and lower sigmoid, as has been taught.

Fourth.—Many cases of so-called appendicitis, occurring in patients under twenty, are cases of intestinal irritation, due to the presence of intestinal parasites.

Fifth.—A study of the fæces in all doubtful cases is of value; and before operation, in doubtful cases, antivermifugal treatment should be given.

Sixth.—The treatment of acute appendicitis, irrespective of causative factor, is surgical.

The July number of *The Annals of Surgery* has just come to hand and is worthy of special mention because of the extraordinary voluminousness. The regular issue of this journal contains 144 pages, but this one contains 344—about the size and value of a $5.00 book. About 26 articles, representing the choicest collection of papers presented at the meeting of the Americal Surgical Association, held in Philadelphia in June, are included in this number, as well as an exceptionally large number of illustrations, bibliographies, and case histories. The value of this special number must be readily recognized by everyone.

CURRENT MEDICAL LITERATURE.

Appendicitis and Other Diseases of the the Vermiform Appendix. By Howard A. Kelly, M. D. With 215 original illustrations, some in colors and 3 lithographic plates. Philadelphia and London. J. B. Lippincott Company. Price.

One scarcely knows whether to admire most the tireless energy of Dr. Kelly, or the skill and thoroughness with wnich he carries out his monumental works.

It is less than a quarter of a century since the word appendicitis was introduced, yet here we have a large octavo volume of 500 pages devoted to a consideration of this disease, and other affections of an organ so insignificant that it required centuries of observation to convince us that it was really the starting point of one of the most dreaded and fatal diseases.

Those who are familiar with Dr. Kelly's great work on Operative Gynæcology will be prepared for the erudition, the exactness, and the minute detail everywhere evident in tnis new work.

The first chapter is historical, it is interesting reading and seems to us written with judgment and impartiality. The word "four," page 13, line 22, seems to be a misprint for "five." In a review of the first five cases of operation on the diseased appendix, it is of interest to the readers of the Maritime Medical News to know that the first operation performed for an appendicitis during the interval, was done by our fellow country man, Charles J. Symnods, a New Brunswicker, surgeon to Guy's hospital, London. But the date of his operation is given incorrectly as 1885. The operation was done in July, 1883, and thus preceded that by Kronlein. In Symonds' case a positive diagnosis was made by the late lamented Dr. Mahomed, of abscess with fæcal concretion, but owing to adhesions, the abscess was opened and the concretion removed without opening the peritoneal cavity.

The chapter on the anatomy of the appendix occupies 27 pages, of which nine are full page plates, with at least 32 other illustrations — macro- and micro-scopic. In the chapter on the physiology of the appendix we note that no reference is made to the interesting Huxley Lecture by Sir William Macewin in 1904.

After a short chapter on the bacteriology of appendicitis which shows the importance of the bacillus coli, we have three chapters (82 pages) on pathology.

We note that cases of acute appendicitis are classified pathologically as (a) catarrhal, (b) diffuse, (c) purulent, (d) gangremous, and (e) perforative

In Sprengel's view the simplest form of appendicitis presents a lencocytic infiltration of all the layers of the wall, and he does not recognize the existence of an inflamation restricted to the mucous layer, and therefore he considers the term endo-appendicitis as incorrect. Kocher also agrees with Sprengel and Korte that the expression diffuse is superfluous and would throw these two classes into one. Kocher holds that wherever we have real clinical symptoms of appendicitis we have a general infiltration of all the layers of the wall. These authorities also hold that perforative appendicitis does not require a class by itself in acute types, as the perforation is the direct result of gangrene. Kocher would reserve the term "perforative" for those cases in which perforation occurs in the course of chronic or re-

lapsing appendicitis, as the result of slow insidious necrotic danger in the tubes.

In the chapter dealing with etiology the first place is given to disorders of digestion, while it appears that concretions even when present probably play a subsidiary role.

The chapter on clinical history will repay the most careful perusal. Most of us will endorse the statement quoted from Gay, that appendicitis is "the most treacherous of known diseases." We wish we could accept as readily the dictum if Dieulafoy that "no one should die of appendicitis." For many die of the disease who have no medical aid, and, too often, when such aid can be had, the difficulties of diagnosis are almost insurmountable and the conditions present make operation hopeless. Three serious hindrances would be greatly lessened if every practitioner could "read, learn, and inwardly digest" these earlier chapters on pathology, clinical history and diagnosis. The chapters on treatment are of fascinating interest, and the illustrations are beyond all praise, but interesting and instructive as these chapters are, the foundations of successful treatment are found in accurate pathology and acute clinical observation.

There are noteworthy chapters on appendicitis and typhoid fever, appendicitis in youth and old age to the relation of appendicitis to gynæcology and obstetrics neoplasms, specific infections, and one on the needed legal aspects of appendicitis.

We have already referred to the illustrations: Dr. Kelly is happy in his choice of artists, and the artists are fortunate in the skill of those who reproduce their work. These pictures are superb. A tired doctor, too tired to read, may pick up this book, and, turning over these marvellous pages will learn more about appendicitis and its treatment, from the pictures alone, than from any written page, not so illustrated.

The Third Report of the Welcome Research Laboratories at the Gordon Memorial College, Khartoum. By ANDREW BALFOUR, M.D., Director. Toga Publishing Co., 110 Coristine Building, St. Nicohlas St., Montreal. Price, $5.00.

The third report of the Wellcome Research Laboratories, Khartoum, is a valuable and very interesting work, especially to those concerned in any way with the progress of tropical medicine which has made vast strides during the past twenty years. This volume comprises 477 pages, with over 350 illustrations, some very beautiful.

The functions of the Research Laboratories cover a wide field and are as follows:—

a. To promote technical education.

b. To promote the study, bacteriologically and physiologically, of tropical disorders, especially the infective diseases of both man and beast peculiar to the Sudan, and to render assistance to the officers of health, and to the clinics of the civil and military hospitals.

c. To aid experimental investigations in poisoning cases by the detection and experimental determination of toxic agents, particularly the obscure potent substances employed by the natives.

d. To carry out such chemical and bacteriological tests in connection with water, food stuffs, and health and sanitary matters as may be found desirable.

e. To promote the study of disorders and pests which attack food and textile producing and other economic plant life in the Sudan.

j. To undertake the testing and assaying of agricultural, mineral and other substances of practical interest in the industrial development of the Sudan.

The Director, Dr. Balfour, is also Health Officer of Khartoum, and in this capacity he gives details of the water supply, the conservancy methods, disposal of sewage, the milk supply, etc., etc. Many of the contributions to the Report are extremely interesting, especially those of Dr. Wenyon who conducted researches on board a floating laboratory, moving up and down the Nile and its tributaries—of Dr. Pirrie on the characteristics of the Nilotic Negroid tribes, of Dr. Cummins on Kala Azar, and of Beam on the chemistry and bacteriology of gum-arabic.

Complete reports of the work done in the Wellcome Laboratories can be obtained from the Toga Publishing Co. of Montreal.

* * *

Common Disorders and Diseases of Childhood. By G. F. Still, M.D., F.R.C.P., Professor of Diseases of Children, King's College, London, etc., etc. Price, $4.50 Oxford Medical Publications. Toronto, D. T. McAinsh & Co., 1909.

The new work of Dr. George F. Still on the "Common Disorders and Diseases of Children," is before us. For the most part the title is a true description of the book, the common maladies of children met with in private practice are considered. Diagnosis and treatment occupy the greater part of the work and consequently will appeal to the ordinary practitioner. The chapters on infant feeding are well worth careful reading and study. The work embodies the large clinical experience of Dr. Still and consequently is a distinct contribution to the literature of Pediatrics.

Illustrated Clinical Lectures and Especially Prepared Original Articles. By Leading Members of the Profession Throughout the World. Volume I and II, Nineteenth Series, 1909. Published by J. B. Lippincott Company, Philadelphia and London.

At this time when so many leagues have been formed against the spread of tuberculosis, the first chapter in Volume I on "The Hospital for Advanced Cases of Tuberculosis," by L. F. Flick, M. D., of Philadelphia, is very apropos. Dr. Flick's first sentence hits the nail on the head: "The hospital for advanced cases of tuberculosis and for early cases in the acute stage of the disease is our most valuable asset in the crusade against tuberculosis." Where hospitals have been built in the larger cities for advanced cases, Dr. Flick has clearly shown that, owing to isolation, the percentage of reduction in the mortality has been marked.

Dr. C. P. Howard of the Montreal General Hospital, contributes a most instinctive article on "Mikulicz's Disease and Allied Conditions." A series of case reports is given, several of which were under observation with Dr. Osler at the Johns Hopkins Hospital. This contribution will repay the reader's attention.

"Absorption from the Peritoneal Cavity," by W. G. MacCallum, M. D., of Johns Hopkins University, deals with the effects of soluble and insoluble substances, and valuable data are given from observations of the author and others. Progress of Medicine during 1908 comprises over 100 pages and contains much valuable information culled from the writings of eminent observers.

Some practical articles in Volume II are: "Immunization Against Typhoid Fever," by Harlan Shoemaker, M. D., of Philadelphia; "Mineral

Waters in the Treatment of Syphilis," by C. de la Carriere, M. D., of Paris; "Diagnosis and Treatment of Pneumonia in Children," by Louis Fischer, M. D., of New York; "Tuberculosis Serofibrinous Pleurisy and its Treatment," by H. B. Allyn, M. D., of Philadelphia; "Diabétes," by E. F. Wells, M. D., of Chicago

Dr. A. G. Ellis, M. D., associate in Pathology, Jefferson Medical College, contributes an admirable contribution on "The Pathogenesis of Spontaneous Cerebral Hæmorrhage," twenty-eight pages and illustrated by several excellent plates.

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Gout. By Prof. H. Strass, Berlin Translated by Nellis Barnes Foster, M.D. E. B. Treat & Co., New York, $11.00.

This book has been written in the interests of the general practitioner by a clinician of wide experience and an expert investigator of disease. The latest ideas are presented in a clear succinct manner. The greater part of the volume is devoted to the pathogenesis and therapy of gout. The section devoted to therapy is characterized by breadth of view and fullness of details. To any one desirous of becoming acquainted with recent advances of knowledge in respect to this malady, we can strongly recommend this small, pithy volume.

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Angina Pectoris. By Edmund Von Neusser, Vienna. Translated by Andrew McFarlane, M.D. E. B. Treat & Co., New York, 1909. $1.00.

Prof. Von Neusser's contributions to medicine are based upon a wide and varied clinical experience, and this monograph is one of his best. The symptomatology is well presented and unusual radiations of pain as well as the relation of angina pectoris to blood pressure, are very fully discussed.

In discussing the etiology the author is content with presenting well known facts without bias rather than to advocate any special theory of causation. The section devoted to functional forms of angina pectoris and differential diagnosis is exceptionally interesting. The section devoted to therapy is rather disappointing, by reason of its brevity and absence of novel suggestions.

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Province of Nova Scotia, Department of Public Health—Health Circulars 23, 24, 25, 26. By A. P. Reid, M. D. Provincial Health Officer.

The above numbered circulars deal with Milk Supply, Water Supply, Sewage Disposal for Isolated Residences and Tuberculosis. Circular 25 deals exhaustively with suburban house drainage, and contains a very interesting communication from F. W. W. Doane, city engineer, Halifax. A full and exhaustive account of the septic tank, the latest device for the disposal of sewage for isolated houses, is given. These circulars should be widely distributed.

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Annual Report of the Victoria Public Hospital, Fredericton, N. B., 1908.

This hospital was founded mainly by the exertions of Lady Tilley and has been in operation for twenty years. At present it has accommodation for forty patients. During 1908 over two hundred patients were treated, and it is evident that excellent work was done. The report itself is clearly printed and very fully illustrated.

Some practical considerations in dealing with pulmonary tuperculosis. By J. H. Elliott, M. D. Toronto.

Reprinted from the *Montreal Medical Journal*, Jan., 1909, pp. 30. This reprint embodies the subject matter of an address delivered by the writer at the Montreal Tuberculosis Exposition held at Montreal last November. Dr. Elliott's wide experience enables him to bring out the salient points in the treatment and prevention of tuberculosis with freedom from technicalities and in a way which they can be easily understood by intelligent laymen.

The Present Status of Anti-Tuberculosis Work in Canada, 1908. By J. H. Elliott, M.B., Toronto.

This most admirable pamphlet prepared for presentation at the Washington meeting of the International Congress on Tuberculosis should be in the hands of every one interested in the propaganda against tuberculosis in Canada. An endeavour has been made to incorporate everything which has a bearing on special anti-tuberculosis work in Canada. It is a short review of the various agencies at work and to some extent of what has been accomplished.

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ANTIPYRETIC, ANALGESIC AND ANTISEPTIC POWER.

In speaking of the treatment of articular rheumatism, Hobart A. Hare, M. D., professor of Therapeutics in the Jefferson Medical College and editor of *The Therapeutic Gazette*, says: "Any substance possessing strong antipyretic power must be of value under such circumstances." He further notes that the analgesic power of the coal-tar products "must exert a powerful influence for good." The lowering of the fever, no doubt, quiets the system and removes the delirium which accompanies the hyperpyrexia, while freedom from pain saves an immense amount of wear, and places the patient in a better condition for recovery. The researches of Guttmann show conclusively that these products

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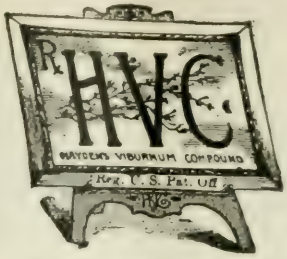

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possess a direct anti-rheumatic influence, and among those remedies, antikamnia stands pre-eminent as an analgesic and antipyretic. Hare, in his *Practical Therapeutics*, says: "Salol renders the intestinal canal antiseptic," a condition absolutely essential in the treatment of rheumatism. In short, the value of salol in rheumatic conditions is so well understood and appreciated that further comment is unnecessary. The statements of Professors Hare and Gutmann are so well known and to the point and have been verified so often, that the uses of "Antikamnia and Salol Tablets" are at once apparent. Each of these tablets contains two and one-half grains of antikamnia and two and one-half grains of salol. The proper proportion of the ingredients is evidenced by the popularity of the tablets in all rheumatic conditions.

THE IMPORTANCE OF NUTRITIVE REPAIR.

The importance of nutritive repair in the treatment of all bodily disorders, associated with loss of weight and general vitality, is too patent to need more than passing emphasis. The question of how best to bring about such a desirable result is, however, one that the physician is daily called upon to answer, and upon his ability to "build up" his more or less devitalized patients will largely depend his success in the treatment of chronic affections. Taking, for example, a patient suffering from Pulmonary Tuberculosis in the incipient or secondary stage, what are the approved measures to adopt to bring about improvement of nutrition and a consequent gain of weight and strength? All phthisio-therapists now agree that the therapeutic trinity of salvation for the tuberculous in-

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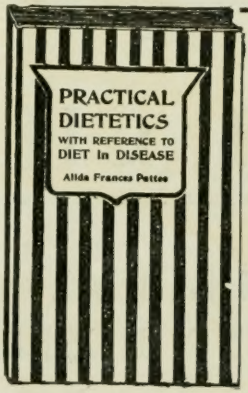

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